NH DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE DIRECTIVE	CHAPTER Health Services STATEMENT NUMBER 6.14
SUBJECT: **TREATMENT/SERVICE PLAN** PROPONENT: Robert MacLeod, Administrative Dir. *Name/Title* Medical/Forensic Services 271-3707 *Office* *Phone #*	EFFECTIVE DATE 01/01/06 REVIEW DATE 12/15/07 SUPERSEDES PPD# 6.14 DATED 12/15/01
ISSUING OFFICER: *William Wrenn, Commissioner*	DIRECTOR'S INITIALS DATE APPENDIX ATTACHED: YES NO
REFERENCE NO: See reference section on last page of PPD.	

I. PURPOSE:
The Treatment/Service Plan, consisting of Treatment/Service Plan reports, Goal Sheet and Treatment/Service Plan reviews, the extent of which shall be dependent upon the resident's length of stay, shall be initiated, maintained and monitored for each resident receiving inpatient services at the Secure Psychiatric Unit (SPU).

II. APPLICABILITY:
To all SPU staff involved in direct patient care.

III. POLICY:
It is the policy of the Secure Psychiatric Unit to provide a special health program for all residents who reside in SPU. All residents of SPU receive close medical/psychiatric supervision. A written, individual treatment plan, with directions to health care to include an objective treatment plan, staff action and supervision of the resident is developed for each resident by the appropriate physician, dentist, or qualified mental health practitioner based on an assessment of their needs.

IV. PROCEDURE:
A. Initiation of the Treatment/Service Plan
1. The treatment plan coordinator assigned to the resident and the resident's attending physician shall be responsible for initiating the multi-disciplinary treatment/service plan process no later than the first working day following admission.
2. The treatment plan shall be based on multi-disciplinary assessments and a discussion of pertinent events that led to the current hospitalization. The resident's psychiatric and medical histories will be reviewed.
3. The master treatment or service plan shall be documented in the resident's record by the 10th day after admission and shall be based on the following information:
a. Reason for admission
b. Mental status
c. Medical history
d. Physical examination results

e. Drug use profile
f. Results of diagnostic tests
g. Psychiatric history and assessment
h. Social history and assessment
i. Psychological assessment
j. Nursing assessment
k. Therapeutic activities assessment
l. Resident, family and staff input
m. Transfer data

4. The treatment/service plan process for Court-ordered evaluation shall be guided by the following standards:
   a. If the resident has signed an Authorization for Treatment, a service plan may be initiated to identify objectives for maintenance of the resident during the evaluation process.
   b. If the resident has not signed an Authorization for Treatment, a service plan may be initiated to identify objectives for maintenance of the resident during the evaluation process. A Weekly Management Report, written as a progress note, shall be used to describe the status of the evaluations and how the resident has managed.
5. Involvement of the resident in the treatment plan process shall be documented to reflect the following questions:
   a. At resident intake:
      1) Reason for this admission to the Secure Psychiatric Unit
      2) What the resident wants to have happen as a result of treatment
      3) What are the resident's goals
      4) What the resident sees as needs, interests and strengths
      5) What are the resident's ideas, questions or concerns
   b. At team meetings:
      1) What aspects of treatment are more or less important to the resident
      2) Does the resident have goals that are important
      3) Does the resident have recommendations regarding the Treatment Plan
      4) Does the resident have any questions regarding staff recommendations
      5) Does the resident think they are making progress
6. Team meetings shall:
   a. Be coordinated by a team leader
   b. Be regularly scheduled
   c. Have advance notification to the team members of the resident to be discussed
   d. Be attended on time
   e. Be time-limited
   f. Secure input from all disciplines
   g. Include review of problems and goals
   h. Include review of the resident's response to treatment interventions
   i. Include discussion of the resident's strengths
   j. Include discussion of discharge plan
   k. Include statement of residents concerns, complaints, suggestions and their own view of progress
   l. Include staff signature of treatment plan review
7. These important points shall be heeded in the development of the comprehensive treatment plan:
   a. The focus shall be on the precise reason (s) for admission; this will usually be a behavior as a manifestation of an underlying diagnosis or condition
   b. The resident's strengths shall be emphasized in planning treatment
   c. The resident's needs shall be stated in positive ways; what the resident will do

rather than what they won't do

d. The plans shall be realistic. Not all goals will necessarily be obtainable during the current episode of care
e. Flow Sheets will be used in a way that aids in an objective review of the resident's progress or lack of progress and will integrate clearly with the plan and summary progress notes
f. Discharge planning will be initiated during the first team meeting or earlier
g. Documentation shall be clear, concise, objective and legible

B. Maintenance of the Treatment/Service Plan:
1. The Treatment Plan Coordinator and the attending physician shall be responsible for maintenance of the multi-disciplinary treatment/service plan process.
2. Maintenance shall occur as a result of ongoing resident evaluation, to include:
a. Assessments of the resident's status and review of goals
b. Recommendations of the resident and family
c. Revisions of the problems and needs from the perspectives of resident and family members
d. Revisions of the resident's strengths
e. Revisions of realistic long and short-term goals and objectives that attempt to use the resident's strengths and to deal with the resident's needs and to state time expectations
f. Identification of treatment modes and their relationship to goals and objectives
g. Plans for discharge and follow-up
3. Review and updating of the treatment plan shall be done when clinically indicated and/or no later than 30 days following the first 10 days of treatment and every 60 days thereafter for the first year of treatment. Following one year of treatment, reviews shall be conducted no less than at three-month intervals.
4. Discharge planning shall continue throughout the maintenance process and shall consider the following needs of residents:
a. Personal preferences
b. Family relationships
c. Physical and psychiatric needs
d. Financial need
e. Housing needs
f. Employment needs
g. Educational/vocational needs
h. Social needs
i. Accessibility to community resources

C. Monitoring of the Treatment/Service Plan
1. The Treatment Plan Coordinator assigned to a resident and the attending physician shall be responsible for monitoring the completeness of the multi-disciplinary Treatment/Service Plan and associated clinical documentation that reflects the resident's progress.
2. It shall be the responsibility of the attending physician to supervise the overall care given as planned for by the treatment team and to record in the summary progress notes any disagreement with the course of care and their plan for follow-up action.

REFERENCES:

Standards for the Administration of Correctional Agencies
Second Edition. Standards

Standards for Adult Correctional Institutions
Fourth Edition Standards
4-4350

Standards for Adult Community Residential Services
Fourth Edition. Standards

Standards for Adult Probation and Parole Field Services
Third Edition. Standards

Other

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